Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Alabama** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Home and Community Based Services Waiver for Individuals with HIV/AIDS and Related Illnesses

C. **Waiver Number: AL.40382**
Original Base Waiver Number: AL.40382.

D. **Amendment Number: AL.40382.R01.01**

E. **Proposed Effective Date:** *(mm/dd/yy)*
10/01/11

Approved Effective Date: 10/01/11
Approved Effective Date of Waiver being Amended: 10/01/07

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	2
☑ Appendix A – Waiver Administration and Operation	A2; QI a.i.
☑ Appendix B – Participant Access and Eligibility	B6 d; QI a.i.a.
☑ Appendix C – Participant Services	QI a.i.a.-c.

☑ **Appendix D – Participant Centered Service Planning and Delivery**	QI a.i.a-e.
☐ **Appendix E – Participant Direction of Services**	
☑ **Appendix F – Participant Rights**	F1
☑ **Appendix G – Participant Safeguards**	QI a.i.
☑ **Appendix H**	H1 a.i
☑ **Appendix I – Financial Accountability**	QI a.i.
☐ **Appendix J – Cost-Neutrality Demonstration**	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
The changes proposed in the amendment include the following: change name of Operating Agency, add performance measures, revise nursing facility level of care critieria, and revise the Fair Hearing process.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Alabama** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Home and Community Based Services Waiver for Individuals with HIV/AIDS and Related Illnesses

C. Type of Request: amendment

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: AL.40382
Waiver Number: AL.40382.R01.01
Draft ID: AL.02.01.01

D. Type of Waiver *(select only one):*
Model Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/07
Approved Effective Date of Waiver being Amended: 10/01/07

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved

Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
The state does not limit the waiver to subcategories of nursing facility level of care.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The HIV/AIDS Waiver allows individuals with a diagnosis of HIV/AIDS and related illnesses who are at risk of nursing home placement to remain in the community as long as their health and safety is not at risk. The waiver seeks to provide quality, supportive, and cost effective services to individuals at risk of institutional care. Many services provided in this and other HCBS waivers offered by the state are traditionally not covered or available under the Medicaid State Plan.

The Alabama Medicaid Agency is the administering agency for this program and the Alabama Department of Senior Services ADSS) is the operating agency. As the operating agency ADSS is responsible for the daily management and operation of the program. In the daily management of the program ADSS focuses on client outcomes such as improving client care, protecting client health and welfare, offering the client free choice of providers for waiver services and waiver service staff. Other ADSS management responsibilities also include assuring all direct service providers meet the required provider qualifications. The following services are provided in the HIV/AIDS Waiver program: case management, personal care, homemaker, respite, (skilled and unskilled),skilled nursing and companion services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level (s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions

of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Prior to submission of the initial waiver application for Individuals with HIV/AIDS and Related Illnesses the Medicaid Agency held a number of meetings with respresentatives from the Alabama Department of Public Health,AIDS Alabama and other Community Based Organizations with an interest in the population served by this waiver.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Tompkins
First Name:	Melody
Title:	Administrator, LTC Specialized Waiver Programs
Agency:	Alabama Medicaid Agency
Address:	501 Dexter Avenue
Address 2:	P.O. Box 5624
City:	Montgomery
State:	**Alabama**
Zip:	36103-5624

Phone:	(334) 353-4383 **Ext:** ☐ **TTY**
Fax:	(334) 353-5536
E-mail:	melody.tompkins@medicaid.alabama.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Stone
First Name:	Jean
Title:	Division Chief
Agency:	Alabama Department of Senior Services
Address:	770 Washington Ave, Suite 570
Address 2:	
City:	Montgomery
State:	**Alabama**
Zip:	36104
Phone:	(334) 242-5743 **Ext:** ☐ **TTY**
Fax:	(334) 242-5594
E-mail:	jean.stone@adss.alabama.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments. Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Marilyn Chappelle State Medicaid Director or Designee
Submission Date:	Dec 20, 2011

Last Name:	Mullins, Jr., MD
First Name:	R. Bob
Title:	Commissioner
Agency:	Alabama Medicaid Agency
Address:	501 Dexter Avenue
Address 2:	
City:	Montgomery
State:	**Alabama**
Zip:	36103-5624
Phone:	

(334) 242-5600

Fax: (334) 242-5097

E-mail: r.bob.mullins@medicaid.alabama.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   Alabama Department of Senior Services (ADSS)

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The HIV/AIDS and Related Illnesses (AIDS) Waiver is administered by the Long Term Care Division of the Alabama Medicaid Agency (AMA)and operated by the Alabama Department of Senior Services (ADSS).

The Medicaid Agency exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The Medicaid Agency assumes the responsibility of:
1) Ensuring that providers meet all provider standards.
2) Conducting joint trainings with direct service providers enrolled to provide services through the AIDS Waiver program.
3) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the AIDS Waiver program. These policies are outlined in the AIDS Waiver manual.
4) Conducting annual training to disseminate policies, rules and regulations regarding the home and community based waiver programs.

The ADSS is the operating Agency for the AIDS waiver and is delegated the responsibility by the AMA of:

- Providing participants with free choice of providers and waiver service workers,
- Ensuring all direct service providers meet the qualifications as outlined in the waiver document,
- Ensuring the health and welfare of participants,
- Improving care received by participants, and
- Ensuring program compliance with the waiver document and the requirements of the AMA.

ADSS works collaboratively with the AMA to conduct an annual quality assurance review to ensure that the process and instruments described in the approved waiver are applied. When deficiencies are noted a plan of correction is requested by AMA staff so that recommendations made by AMA as a result of the quality assurance reviews are addressed by ADSS and the Direct Service Providers (DSP).

Reviews of participant files, personnel files, and home visits are methods the state uses to monitor compliance with level of care determinations, appropriateness of the plan of care, that qualified providers are rendering services in accordance with the waiver document so that the health and welfare of the participant is ensured. The reviews also ensure that participants are informed and knowledgeable about the complaint and grievance process and that ADSS has a process in place to address, track and resolve complaints and grievances.

The state has also developed a Quality Management Strategy for the AIDS Waiver.

The following activities are components of the Quality Management Strategy:

1. Collect ongoing monthly data to monitor appropriateness of level of care determinations. A 10% random monthly retrospective review is performed by an AMA nurse reviewer.
2. Quarterly data is collected by registered nurses reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant's homes and conducting consumer satisfaction surveys, and tracking complaints and grievances.
3. Remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved.

4. Data collected is reported quarterly and annually to the Department of Senior Services and AMA staff for evaluation and recommendations for program improvements.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
	☑	☑
Participant waiver enrollment	☐	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☐	☐
Utilization management	☑	☑
Qualified provider enrollment	☐	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☑
	☑	☑
Rules, policies, procedures and information development governing the waiver program	☐	☐
Quality assurance and quality improvement activities	☐	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the

following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of LOC determinations completed in time specified in the agreement with the Medicaid Agency.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	**Frequency of data collection/generation**(*check each that applies*):	**Sampling Approach**(*check each that applies*):
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	**Frequency of data collection/generation**(*check each that applies*):	**Sampling Approach**(*check each that applies*):
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans for new enrolles completed in time frame specified in the agreement with the Medicaid Agency

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that applies):*	**Frequency of data aggregation and analysis** (*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents investigations completed within time frames specified in the agreement with the Medicaid Agency

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of provider reviews conducted with the frequency required in the agreement with the Medicaid Agency

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of quality assurance record reviews conducted each month as compared to what was specified in the agreement with the Medicaid Agency

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☑ Other Specify: 10%
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of provider agreements/contracts that adhered to the states uniform agreement/contract requirements

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	Frequency of data collection/generation(*check each that applies*):	Sampling Approach(*check each that applies*):
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	Frequency of data collection/generation(*check each that applies*):	Sampling Approach(*check each that applies*):
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☑ Other Specify: 10%
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Alabama Medicaid Agency (AMA) exercises administrative authority and responsibility of all waiver related policies and the OA's adherence to rules and regulations governing the HIV/AIDS Waiver. AMA conducts annual training to disseminate policies, rules and regulations in an effort to ensure consistent application of the policies related to the HIV/AIDS Waiver program. The Commissioner of the AMA signs all direct service contracts of qualified providers enrolled with the OA every 3 years to ensure quality waiver services are provided.

AMA reviews participant files, personnel files and performs home visits (as needed) as a method to monitor compliance in:
The level of care determination process:
The appropriateness of the plan of care; and
The monitoring of services to ensure quality care is provided by providers contractyed with the OA.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
AMA LTC Division is responsible for collecting data from the OA quarterly and annually regarding the quality of services provided from various sources for the HIV/AIDS Waiver program. The Quality Framework is used as a guide to assess seven Program Design Focus areas: samples of waiver participants, case management and direct service providers' records, and on-site home visits when deemed necessary. In addition, participant satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-traced with targeted surveys to determine participants' satisfaction with resolutions.

Data is collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants records approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the participant are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months. After the third request for a plan of correction, and the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued.

The collected data is reported quarterly and annually to each Operating Agency. AMA LTC Division will evaluate reports and make recommendations for improvements to the program. The AMA LTC Division will determine if changes are to be made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access
Sources of data:
Case Management Records
Home Visits
DSS Queries
Consumer Surveys

Participant–Centered Service Planning and Delivery
Sources of data:
Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities
Sources of data:
Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards
Sources of data:
Case Management Records
Consumer Surveys
Home Visits
Site Visits

Participants Rights and Responsibilities
Sources of data:
Consumer Surveys
Case Management Records
Complaint and Grievances Logs
Targeted Surveys

Patient Satisfaction
Sources of data:
Consumer Surveys
Case Management Records
Home Visits
Site Visits

System Performance
Sources of data:
Review of Operating Agency Quality Assurance System
Review of Operating Agency Billing and Service Provision
Collaborative Meeting with Operating Agency to enhance the administration of the Program
Subcontractor Client Records

The following indicators are reported to the operating agency and Medicaid's Long Term Care Division:

- Percentage of participant/family reporting satisfaction with waiver services and needs met.
- Percentage of participant/family reporting they feel safe and secure in the home and community.
- Percentage of participant/family reporting they have ready access to services and were informed of sources of support available in the community.
- Percentage of participant/family reporting knowledge of rights and responsibilities.
- Percentage of records indicating services are planned and implemented according to the participant's needs and preferences.
- Evidence that the operating agency has a Quality Assurance System in place that monitors subcontractors.
- Evidence that the operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

Data is collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants records approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the participant are being met, and to gain input about the quality of the services received.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one*

waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☑	HIV/AIDS	21		☑
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The AIDS Waiver also provides services to individuals with HIV/AIDS and related illnesses who meet the nursing facility level of care.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the

State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- **A level higher than 100% of the institutional average.**

  Specify the percentage:

- **Other**

  Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a

waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The state provides entrance to the waiver for all eligible persons with a diagnosis of HIV/AIDS and Related Illnesses who meet the nursing facility level of care and who meet the financial criteria for waiver eligibility.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134, 435.135, 435.137, 435.138, Section 6 of Public Law 99-643, and individuals deemed eligible for AFDC under 42 CFR 435.145 and 435.227.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of the FBR, which is less than 300%**

  Specify the percentage:
- **A dollar amount which is less than 300%.**

  Specify dollar amount:
- **A percentage of the Federal poverty level**

  Specify percentage:
- **Other standard included under the State Plan**

  Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:

  The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.
- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable (see instructions)**
- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By an entity under contract with the Medicaid agency.**

Specify the entity:

The Alabama Medicaid Agency (AMA) has granted the Alabama Department of Senior Services' (ADSS) nurse reviewer the authority to make the level of care determinations. In the event that the ADSS nurse reviewer is unable to make the level of care determination the application is referred to the AMA for approval or denial.

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

A nurse reviewer employed by the ADSS is responsible for performing the level of care determination. The Nurse Reviewer is a registered nurse with an active license issued by the Alabama Board of Nursing.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The HIV/AIDS Waiver program serves recipients that meet the nursing facility level of care. At least two (2) of the following nursing facility level of care criteria must be met for initial determinations and re-determinations to be able to evaluate and reevaluate applicants and recipients for waiver services:

A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.
B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.
C. Nasopharyngeal aspiration required for the maintenance of a clear airway.
D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
E. Administration of tube feedings by nasogastric tube.
F. Care of extensive decubitus ulcers or other widespread skin disorders.
G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (providing supporting documentation).
H. Use of oxygen on a regular or continuing basis.
I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physician's orders.
J. Comatose resident receiving routine medical treatment.
K. Assistance with at least one of the activities of daily living below on an ongoing basis:

1. Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).
2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).
7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.
8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).
9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

If an individual meets one or more ADL deficits within criterion (k), they must also meet an additional criterion, (a) through (j), accompanied by supporting documentation, as is currently required. Multiple items met under (k) will still count as one criterion.

Also note, Criterion (a) is also the same as Criterion (k) 7. Therefore, if an individual meets criterion (a), criterion (k) 7, cannot be used as the second qualifying criterion.

Additionally, Criterion (g) is the same as Criterion (k) 9. Therefore, if an individual meets criterion (g), Criterion (k) 9, cannot be used

as the second qualifying criterion.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The case manager performs a thorough assessment of the applicant/recipient living situation, their ability to perform activities of daily living, available community resources, support from family/others and develops a plan of care to address any gaps which place the applicant/recipient at risk for institutionalization. Medical certification is then obtained from the attending physician. Information gathered from the case manager and the attending physician is forwarded to the Nurse Reviewer at ADSS for a level of care determination. A level of care determination for an applicant/recipient is processed based upon information contained on the HCBS-1 assessment as well as physician progress notes and /or hospital records as needed or requested by the nurse reviewer. The appropriateness of placement on the waiver or the continuation of waiver services involves consideration of the aforementioned factors as well as the functional limitation of the individual, medical diagnosis, support systems in place and any other factors which place the individual at risk for institutionalization. Applicants must meet two criteria as defined in B-6. (d). At annual redetermination recipients are required to meet two criterion as defined in B-6. (d). for continued eligibility.

If the ADSS Nurse Reviewer is unable to make the level of care determination, the application is referred to the AMA for approval or denial. The AMA has granted the ADSS Nurse Reviewer the authority to make the level of care determinations. During the audits of an Operating Agency, the AMA Quality Improvement and Standards Division Nurse Reviewer may also review the application to determine if the HIV/AIDS Waiver level of care is appropriate.

If the recipient's medical eligibility is still questionable, in terms of whether they meet the level of care, is at risk of institutionalization, or is appropriate for admission to the HIV/AIDS Waiver, the application is forwarded to the AMA Medical Director for review and final determination.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Reevaluations of participant eligibility must be performed every twelve months. The case manager must complete a new application by

the date the current determination expires.

Each month case management staff from the operating agency, ADSS, verify eligibility electronically and/or review the Monthly Exception Report to determine when recipient eligibility should be redetermined. Case managers also maintain a manual tickler file so that redeterminations are performed timely. In an effort to balance the caseload of the case manager a redetermination may be submitted early for approval.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written and/or electronically retrievable documentation of level of care determinations and redeterminations are maintained for maximum a period of five (5) years. Case management records containing the level of care determinations are maintained by the operating agency. Additional documentation is maintained with direct services providers responsible for providing waiver services for (5)years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who received an annual redetermination of eligibility within 12 months of their last redetermination

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☑ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants' level of care determinations forms/instruments that were completed as required by the state

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	Frequency of data collection/generation(*check each that applies*):	Sampling Approach(*check each that applies*):
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	Frequency of data collection/generation(*check each that applies*):	Sampling Approach(*check each that applies*):
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of LOC determinations made by a qualified evaluator

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = 95
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of LOC determinations made where the LOC criteria was accurately applied

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

☐ **Other** Specify:

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that applies):*	**Frequency of data aggregation and analysis** (*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Alabama Medicaid Agency (AMA) has granted the OA Nurse Consultant the authority to make the level of care (LOC) determinations and annual redeterminations (reevaluations). The AMA may assist the OA with difficult LOC evaluations. On a monthly basis, AMA Long Term Care staff will run a query of all HIV/AIDS applications that are accepted into the MMIS system. The AMA LTC Division Nurse Reviewer will randomly select a percentage of applications for retrospective review. The AMA Nurse Reviewers will review the Home and Community Based Waiver (HCBS-1), the admission and evaluation data sheet, physician's progress notes, and/or any other documentation to support the participant's need for services. Documentation must include, the support systems within the home, the functional limitations of the recipient, medical diagnosis, unstable medical condition, and any factors that would place the recipient at risk of institutionalization. Redetermination (reevaluation) must be completed every twelve months.

The process is the same as for an initial evaluation. The OA is responsible for completing the reevaluations in a timely manner, or the claim will deny.

The AMA conducts quarterly Quality Assurance meetings which includes staff from LTC and representatives from staff of the HIV/AIDS (and other waivers) waiver. These meetings are designed to inform, educate, discuss matters of concern etc.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The AMA conducts satisfaction surveys on a quarterly basis. The survey is sent to a random sample of participants/representatives. The purpose of the survey is to evaluate the participant's satisfaction with the waiver services. Any adverse responses are tracked through to a resolution either by the OA or AMA, depending upon the issue. A targeted satisfaction survey is sent out (within 45 days of receipt) as a follow-up to assure the client's satisfaction with the resolution. Results of satisfaction surveys are totaled in percentages using a bar graph. On a quarterly basis the results are sent to the OA. Additionally, the OA is responsible for keeping a log of complaints/grievances that must be tracked through to a resolution. Grievances will be resolved within 45 days of receipt by the DSP, OA, or AMA. Grievances are to be resolved in an appropriate and timely manner. If the grievances are not resolved to the satisfaction of the participant or AMA, the OA will be asked to submit a Plan of Correction to resolve the grievance to the participant's satisfaction, if possible, or to ensure prevention of re-occurrence. If the grievance is not resolved within 45 days, AMA may assist the OA in reaching a satisfactory resolution. In no instance will grievance resolution exceed 90 days of receipt. The OA will be notified of any complaints/grievances received by AMA involving the OA or any of its providers of care within two working days of receipt. Each year the OA performs periodic telephone interviews with 5% of waiver participants statewide to ensure services are provided appropriately and the participant is satisfied with service received. Annually, the OA sends a satisfaction survey to 5% of randomly selected participants receiving waiver services during the year. Responses of dissatisfaction are addressed with the ACT Case Manager who provides follow-up with the participant within three working days and reports findings and resolution to the state office within 30 days of notification. For the provision of Assistive Technology and Environmental Accessibility Adaptations services, the participant must sign a form prior to vendor payment to ensure satisfaction of services. All waiver participants sign a "Problem Solving Guide" at the time of initial application and re-evaluation that provides them with the avenue to reach resolution of any problems. This form provides the contact information for the HIV/AIDS Coordinator at the OA where participant's may lodge complaints at any time. The State Office will notify the HIV/AIDS Case Manager within three working days of the complaint. The HIV/AIDS Case Manager will follow-up on the complaint within three days from the State Office notification. The HIV/AIDS Case Manager will report resolution to the State Office within 30 days of notification of complaint.
HIV/AIDS Nurse Reviewers at the AMA will review a random selection of 5% of waiver participants' records annually to ensure compliance with the waiver document and participant satisfaction with service. Satisfaction of services is reviewed during the monthly home visits and documented in the participant record.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The case manager, employed by the operating agency, verbally informs eligible individuals or their legal representatives of the feasible alternatives available under the waiver, allowing free choice of waiver services or institutional care, during the assessment/application process for admission, readmission, and redetermination of eligibility. Participants and/or their representative are given as much information as possible to allow them to make an informed choice based upon their individual and personal preferences without putting their health and saftey at risk. This information is also provided in writing. The applicant/recipient or their legal representative signs the freedom of choice statement on the Admission and Evaluation Data form (HCBS-1, page 3) which serves as documentation of the individual's choice. The only exception to a written choice is when the participant is not capable of signing the form. The reason for the absence of the signed choice form must be documented in the participant's case record. If the participant has a legal representative that individual may sign the choice form.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice forms are maintained for a minimum of five years by the case management staff in county health department offices.

Appendix B: Participant Access and Eligibility

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Accomodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid Website such as the Covered Services Handbook, and basic eligibility documents.

The language translation line offers numerous languages that applicants/participants may access through the Medicaid toll free telephone number. Translators on the language line can assist the LEP applicant/participant to request and receive any available Medicaid assistance and apply for available Medicaid services.

The Medicaid Agency website also contains a link to AltaVista Babel Fish Translation. This tool enables individuals with limited English proficiency to translate short passages of text or entire web sites among 19 pairs of languages. Babel Fish allows users to grasp the general intent of the original message and does not produce a polished translation.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service	
Statutory Service	Case Management	
Statutory Service	Homemaker	
Statutory Service	Personal Care	
Statutory Service	Respite	
Other Service	Companion Services	
Other Service	Skilled Nursing	

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Case Management(CM)is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and

other State Plan services, as well as needed medical, social, educational, and other appropriate services. CM Service may be used to locate, coordinate, and monitor necessary and appropriate services. CM activities can also be used to assist in the transition of an individual from institutional settings such as hospitals and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain an individual in the community. CM activities may also serve to provide necessary coordination with providers of non-medical and non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible. Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. CM is a waiver service available to all HIV/AIDS (AIDS) Waiver clients. Case Managers assist clients to make decisions regarding long term care services and supports. CM ensures continued access to waiver and non-waiver services that are appropriate, available, and desired by the client.

A unit of service will be fifteen (15) minutes beginning on the date that the client is determined eligible for AIDS Waiver Services and is entered into the Medicaid Long Term Care (LTC) file. CM services provided prior to waiver approval should be considered administrative. At least one face-to-face visit is required monthly in addition to any other CM activities.

For transitional CM a unit of service that assists individuals transitioning from institutional settings into the community will be fifteen (15) minutes beginning on the first date the case manager goes to the institution to complete an initial assessment. There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During the transitioning period it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor.

Within the context of home and community-based services, CM may include, but is not limited to, the following functions:
a. Conducting assessments of need and necessity for waiver services;
b. Completing and processing level of care applications for admission, readmission or redetermination of eligibility;
c. Developing, monitoring, and revising the client's Care Plan in coordination with the client/caregiver;
d. Arranging and authorizing waiver services according to the client's Care Plan;
e. Making referrals and assisting clients to gain access to needed Medicaid State Plan and other non-waiver services;
f. Coordinating the delivery of waiver and non-waiver services included in the client's Care Plan;
g. Monitoring the quality and effectiveness of waiver and non-waiver services provided to the client;
h. Making at a minimum, a monthly face-to-face visit with every active waiver client to monitor the Plan of Care;
i. Monitoring the cost-effectiveness of waiver services for an individual;
j. Processing transfers from county-to-county or from;
k. Facilitating transfers to or from other home and community-based waiver programs; and
l. Transitioning clients who meet the nursing facility level of care from institutional settings such as hospitals and nursing facilities.
m. Reinstating AIDS Waiver Services following a client's short-term nursing home stay;
n. Processing terminations of waiver eligibility and services;
o. Establishing and maintaining case records.

Prior to waiver approval, all potential clients are screened by the CM to access their potential eligibility and to determine their desire for waiver participation. The intake screening activities and eligibility determination are distinct from Direct Case Management but are included in this scope of service since they are preliminary activities necessary for waiver enrollment. With the exception of case management activities for individuals transitioning from an institution into the community, Case Management activities provided to a client prior to waiver approval is considered administrative. Medicaid will not reimburse for activities performed which are not within the scope of service.

The Operating Agency must have a Quality Assurance Program for Case Management Service in place and approved by the Alabama Medicaid Agency. The Quality Assurance Program shall include Case Manager record reviews at a minimum of every sixty (60) days. Documentation of quality assurance reviews and corrective action must be maintained by the Operating Agency and will be subject to review by the Alabama Medicaid Agency.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount, frequency or duration of this service is dependent upon the participant's needs as set forth in the Plan of Care for regular waiver case management. There is a maximum limit of 180 working days under the HCBS waiver to assist an individual to transition from an institutional setting to a community setting. During this 180 day time frame the case manager must make a minimum of 3 face-to-face visits and have monthly contact with the client or the client's sponsor.

In instances in which services are offered by a relative, the State will ensure that there is no conflict of interest by prohibiting the relative who is the direct service provider from participating in the development of the care plan or from signing the service

authorization log.

If a conflict of interest does arise due to a family member being a direct service provider, the State will ensure that another individual be assigned the responsibilities of participating in the plan of care development and signing the service authorization log if the recipient is unable to do so. The ADSS Case Manager will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the plan of care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	State Agency-Case management staff are employees of the state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

State Agency-Case management staff are employees of the state

Provider Qualifications

License *(specify)*:

BSN from an accredited college or university with current license issued from the Alabama State Board of Nursing or Bachelor's degree in Social Work from a program accredited by the Council on Social Work Education and possess or are eligible for a license issued by the Alabama State Board of Social Work Examiners. Professionals eligible for licensure must complete the usual probationary period with continued employment contingent upon being licensed within one year from the date of hire.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Medicaid Agency Waiver Quality Assurance staff are responsible for verifying the license of case management staff.

Frequency of Verification:

Verfication of provider qualifications is monitored annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The Homemaker Service(HM) provides assistance with general household activities such as meal preparation and routine housecleaning and tasks, such as, changing bed linens, doing laundry, dusting, vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. This service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, writing and mailing checks but not signing them.

Homemaker Services are designed to preserve a safe and sanitary home environment, assist clients with home care management duties, to supplement and not replace care provided to clients, and to provide needed observation of clients participating in the HIV/AIDS (AIDS) waiver. A unit of service is fifteen (15) minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.
Homemaker Services duties include, but are not limited to, the following:

a. Meal or snack preparation, meal serving, cleaning up afterwards;
b. General housekeeping which includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;
c. Essential shopping for food and other essential household or personal supplies which may be purchased during the same trip, and picking up prescribed medication;
d. Assistance with paying bills which includes opening bills, writing checks but not signing them and delivering payments to designated recipients on behalf of the client;
e. Assistance with communication which includes placing phone within client's reach and physically assisting client with use of the phone, orientation to daily events, paying bills, and writing letters;
f. Observing and reporting on client's condition;
g. The homemaker is not allowed to transport the client by vehicle in the performance of their task.
h. Reminding clients to take medications

Under no circumstances should any type of skilled medical or nursing service be performed by the Homemaker Worker. Medicaid will not reimburse for activities performed which are not within the scope of service.

The DSP completes a supervisory review every sixty (60) days which includes, at a minimum, assurance that services are delivered and consistent with the POC and the service authorization form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (10) calendar days after the sixty (60) day supervisory review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount, frequency or duration of this service is dependent upon the individual client's needs as set forth in the Plan of Care. While there are no set limits on the amount frequency, or duration or this service it is not available 24 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify)*:

Business

Certificate *(specify)*:

N/A

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Department of Senior Services

Frequency of Verification:

Annual upon initial approval and biannually thereafter if no compliance concerns exist.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*
Personal Care Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, but does not include the cost of the meals themselves, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

Personal Care Service is to help waiver clients perform everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently. The unit of service will be fifteen (15) minutes of direct PC Service provided in the client's residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or the Personal Care Worker's break or mealtime.

THe PC Service duties include:
a. Support for activities of daily living, such as, bathing ,personal grooming, personal hygiene, meal preparation, assisting clients in and out of bed, assisting with ambulation, toileting and/or activities to maintain continence
b. Home support that is essential to the health and welfare of the recipient, such as,cleaning,laundry and home safety. Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PCW Supervisor as well as the Case Manager for follow-up.
c. Reporting observed changes in the client's physical, mental or
emotional condition.
d. Reminding clients to take medication.
e. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The PCW is not allowed to transport clients. Under no circumstances should any type of skilled medical or nursing service be performed by the PCW. Medicaid will not reimburse for activities performed which are not within the scope of service.

The DSP must complete a supervisory review every sixty (60) days which includes, at a minimum, assurance that the services are being delivered consistent with the POC and the service authorization form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (10) calendar days after the sixty (60) day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC Service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, frequency or duration of this service is dependent upon the individual client's needs as set forth in the Plan of Care. While there are no set limits on the amount frequency, or duration of this service it is not available 24 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency or Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Home Care Agency or Home Health Agency
Provider Qualifications
License *(specify):*
Business
Certificate *(specify):*
Certificate of Need(CON)if the provider type is a Home Health Agency.
Other Standard *(specify):*
Waiver of Certificate of Need approved by the Medicaid Commissioner.
Verification of Provider Qualifications
Entity Responsible for Verification:
Alabama Department of Senior Services (Operating Agency)
Frequency of Verification:
Annually upon initial approval and biannually thereafter if no compliance concerns exist.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Respite
Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care. Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household. Respite Care is not an entitlement. The Respite Care service is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary, short term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. The primary caregiver does not have to reside in the residence; however, there must be sufficient documentation to establish that the primary caregiver to be relieved furnishes substantial care of the client. This service must not be used to provide continuous care while the primary caregiver is working or attending school.

Respite Care is intended to supplement, not replace care provided to waiver clients. Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely due to the unavailiability or absence of the primary caregiver. The unit of service is fifteen minutes (15) of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the

client's residence or the Respite Care Worker's break or mealtime.

Skilled Respite Service will provide skilled medical or nursing observation and services and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.
(a) Orders from the client's physician(s)are obtained before service implementation, annually and when changes occur.
(b) It is the responsibility of the Skilled Respite Provider to obtain such physician orders for the skilled nursing services needed by the client.

In addition to providing supervision to the client, Skilled Respite may include, but is not limited to, the following activities:

(a) Assistance with activities of daily living (ADLs), such as, bathing, personal hygiene and grooming, dressing, toileting or activities to maintain continence, preparing and serving meals or snacks and providing assistance with eating, transferring and ambulation.
(b) Home support that is essential to the health and welfare of the recipient, such as, cleaning, laundry, assistance with communication and home safety. Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Case Manager for follow-up.
(c) Skilled nursing services as ordered by the client's physician, including administering medications.
(d) Skilled medical observation and monitoring of the client's physical, mental or emotional condition and the reporting of any changes.
(e) Orienting the client to daily events.

Unskilled Respite Services will provide and/or assist with activities of daily living and observations. In addition to providing supervision to the client, Unskilled Respite may include, but is not limited to, the following activities:
a. Meal or snack preparation, meal serving, cleaning up afterwards;
b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;
c. Assistance with communication which includes placing the phone within client's reach and physically assisting client with use of the phone and orientation to daily events;
e. Support for activities of daily living, such as , bathing, personal grooming,personal hygiene, assisting clients in and out of bed,assisting with ambulation, toileting and/or activities to maintain continence;
f. The Respite Care worker will ensure that the client is residing in a safe environment. any concerns with safety issues will be reported to the RCW Supervisor as well as the Case Manager for follow-up;
g. Reporting observed changes in the client's physical,mental or emotional condition;
h. Reminding clients to take medication.

Under no circumstances should any type of skilled medical or nursing service be performed by an Unskilled Respite Worker. Medicaid will not reimburse for activities performed which are not within the scope of service.

The Skilled and Unskilled Respite Supervisor will provide on-site (client's residence)supervision of the Skilled and Unskilled Respite Care Worker at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the Operating Agency. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by Skilled or Unskilled Respite Care Worker.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year (October 1-September 30) in accordance with the provider contracting period.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
Business/ Active Licensed Practical Nurse license or Registered Nurse license from the Alabama Board of Nursing
Certificate *(specify):*
N/A
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Alabama Department of Senior Services (Operating Agency)and AMA Waiver Quality Assurance Unit.
Frequency of Verification:
Annually upon initial approval and biannually therafter if no compliance concerns exist.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Companion Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Companion Service is non-medical assistance, observation, supervision and socialization provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client. Companion Service is not an entitlement.

The Companion Service is to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the HIV/AIDS Waiver.

A unit of service will be fifteen (15) minutes of direct Companion Service provided to the client. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime.

Companion Service includes:
a. Supervision/observation of daily living activities, such as, reminding client to bathe and take care of personal grooming and hygiene, reminding client to take medication, observation/supervision of snack, meal planning and preparation, and/or eating; and toileting or maintaining continence.
b. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The Companion Worker is not allowed to transport clients, only to accompany them.
c. Supervision/assistance with laundry.
d. Performance of housekeeping duties that are essential to the care of the client
e. Assist with communication.
f. Reporting observed changes in the client's physical, mental or emotional conditions.

Under no circumstances should any type of skilled medical or nursing service be performed by the Companion Worker. Medicaid will not reimburse for activities performed which are not within the scope of service.

The Companion Worker Supervisor will provide on-site supervision at the client's place of residence at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the Companion Worker. Supervisory visits must be documented in the individual client record and a copy placed in the individual's personnel file.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, frequency or duration of this service is dependent upon the individual client's needs as set forth in the Plan of Care. Companion service is available only to those clients who reside alone. While there are no set limits on the amount frequency, or duration of this service, it is not available 24 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:
Agency

Provider Type:
Home Care Agency

Provider Qualifications

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service must not duplicate skilled nursing under the mandatory home health benefit in the state plan. If a waiver client meets the criteria to receive the home health benefit, home health should be utilized first and exhausted before Skilled Nursing under the waiver is utilized.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
Home Care Agency

Provider Qualifications

License *(specify)*:
A business license is required for the home care agency. Registered Nurses or Licensed Practical Nurses employed by the home care agency must have a current license from the Alabama State Board of Nursing

Certificate *(specify)*:
N/A

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Home Care Agency

Frequency of Verification:
Annual upon initial approval and biannually thereafter if no compliance concerns exist.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants *(select one)*:

- ◉ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ○ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that ap to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agei or the operating agency (if applicable).

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for ~~another~~ person and typically includes: (a) the parent (biological or adoptive) of a minor chilc or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

The State does not make payment to relatives/legal guardians for furnishing waiver services.

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

In instances in which services are offered by a relative, the State will ensure that no conflict of interest occurs by prohibiting the relative who is the direct service provider from participating in the development of the care plan or from signing the service authorization log.

If a conflict of interest does arise due to a family member being a direct service provider, the State will ensure that another individual be assigned the responsibilities of participating in the plan of care development and signing the service authorization lo if the recipient is unable to do so. The ADSS Case Manager will montitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the plan of care.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Enrollment of qualified providers is an ongoing process. ADSS enrolls and issues provider contracts to applicants that meet all direct service provider qualifications and standards required by the approved waiver document. All willing and qualified providers are given an opportunity to enroll as an AIDS Waiver provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new provider applications, by type, for which the provider obtained appropriate licensure/certification in accordance with State Law and waiver provider qualifications prior to service provision

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	**Frequency of data collection/generation**(*check each that applies*):	**Sampling Approach**(*check each that applies*):
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Via Medicaid's Fiscal Agent

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and	**Frequency of data aggregation and analysis**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of providers, by provider type, continuing to meet applicable licensures/certification following initial enrollment

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval = ☐ Stratified Describe Group:
☐ Other Specify:	☐ Annually	
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Source (Select one):

Record reviews, off-site
If 'Other' is selected, specify:
Via Medicaid's Fiscal Agency

Responsible Party for data collection/generation *(check each that applies)*:	Frequency of data collection/generation *(check each that applies)*:	Sampling Approach *(check each that applies)*:
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies)*:	Frequency of data aggregation and analysis *(check each that applies)*:
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of agency providers whose direct support staff had timely criminal

background and registry checks

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies*):	**Frequency of data collection/generation**(*check each that applies*):	**Sampling Approach**(*check each that applies*):
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify: 	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that applies*):	**Frequency of data aggregation and analysis** (*check each that applies*):
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify: 	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers, by provider type, meeting provider training requirements

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☑ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of satisfaction survey respondents who reported they do not feel safe when they live

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of satisfaction survey respondents who reported they are not treated with respect and dignity

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☑ Other Specify: 10%
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Case Manager will monitor participants through monthly home visits to observe the participant in the home and note any critical events/incidents appropriately. The Case Manager will also report any events of this nature to the waiver administrator in the approved format who will forward to AMA within the required guidelines. The Case Manager will track reports to resolution for documentation and will report the resolution to the waiver administrator to forward to AMA.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsib parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

AMA conducts participant satisfaction surveys on a quarterly basis. The results of the surveys are relayed to the Operating Agency (OA). The OA is responsible for keeping a log of complaints/grievances that must be tracked through to resolution on an on-going basis. This log is to be sent to AMA on a quarterly basis. Grievances are to be resolved in an appropriate and timely manner, or the OA will be asked to submit a Plan of Correction to ensure prevention of re-occurance. The OA will be notified of any complaints/grevances received by AMA involving the OA or any of its providers of care. The OA performs periodic telephone interviews with waiver participants statewide to ensure services are provided appropriately and to emsure tha the participant is satisfied with services received.

The OA sends a satisfaction survey to 10% of those receiving waiver services during the year. The sample is selected randomly. Responses of dissatisfaction are addressed with the waiver Case Manager who provides follow-up with the client anc reports findings and resolution to the state office. For the provision of Assistive Technology, Environmental Accessibility Adaptations, and Minor Assistive Technology services, the participant signs a form prior to vendor payment to ensure satisfaction of service.

The results of the satisfaction surveys are kept on file and any comment or dissatisfaction is followed up on by the waiver Case Manager through resolution. Each waiver participant, at initial application and each year at the time of the re-evaluation of services will be provided a copy of the HIV/AIDS Waiver Problem Solving Guide that provides them with directions on how to complain to the Case Manager and to the HIV/AIDS Coordinator or their designee. The Case Manager will follow-up with all complaints through resolution.

The AMA Review Coordinator will review a random sample of 10% case management and direct service provider records for recipients of the 530 Waiver, annually to ensure compliance with the waiver documents and participant satisfaction with service provided. Home visits are not routinely completed at this time. Home visits are completed when there is a health and safety concerns that cannot be resolved at the local level.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, anc

the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request throu the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discove and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing an prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectivenes of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a wor plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver i effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related t each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Description of the Quality Management Program for the HIV/AIDS Waiver

The Quality Management Strategy for the HIV/AIDS Waiver is:

AMA LTC Division is responsible for collecting data from the OA quarterly and annually regarding the quality of services provided from various sources for the HIV/AIDS Waiver program. The Quality Framework is used as a guide to assess seven Program Design Focus areas from samples of waiver participants, case management and direct service providers' records, on-site home visits when deemed necessary, and onsite visits to adult day health facilities. In addition, participant satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants' satisfaction with resolutions.

Data is collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input abou the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months. After the third request for a plan of correction, and the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued.

The collected data is reported quarterly and annually to each Operating Agency. AMA LTC Division will evaluate reports and make recommendations for improvements to the program. The AMA LTC Division will determine if changes are to be made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access
Sources of data:
Case Management Records
Home Visits
DSS Queries
Consumer Surveys

Participant–Centered Service Planning and Delivery
Sources of data:
Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities
Sources of data:
Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards
Sources of data:
Case Management Records
Consumer Surveys
Home Visits

Site Visits

Participants Rights and Responsibilities
Sources of data:
Consumer Surveys
Case Management Records
Complaint and Grievances Logs
Targeted Surveys

Patient Satisfaction
Sources of data:
Consumer Surveys
Case Management Records
Home Visits
Site Visits

System Performance
Sources of data:
Review of Operating Agency Quality Assurance System
Review of Operating Agency Billing and Service Provision
Collaborative Meeting with Operating Agency to enhance the administration of the Program
Subcontractor Client Records

The following indicators are reported to the operating agency and Medicaid's Long Term Care Division:

- Percentage of participant/family reporting satisfaction with waiver services and needs met.
- Percentage of participant/family reporting they feel safe and secure in the home and community.
- Percentage of participant/family reporting they have ready access to services and were informed of sources of support available in the community.
- Percentage of participant/family reporting knowledge of rights and responsibilities.
- Percentage of records indicating services are planned and implemented according to the participant's needs and preferences.
- Evidence that the operating agency has a Quality Assurance System in place that monitors subcontractors.
- Evidence that the operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Medicaid Agency LTC Division is responsible for collecting data regarding the quality of services provided from various

sources for the HIV/AIDS Waiver. Data is collected using quality indicators from each of the seven Program Design Focus areas of the Quality Framework as a guide. In addition, quality indicators from adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants' satisfaction with resolutions.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Collected data is reported quarterly and annually to the Operating Agency and to Medicaid's LTC Division for evaluation and recommendations for program improvements. The LTC Division of the Medicaid Agency is the administering authority over the HIV/AIDS Waiver Program; therefore, recommendations for improvements will be evaluated by the LTC Division for final determination of changes to the program.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts t ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced ir the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State of Alabama assures the financial accountability and integrity of waiver payments through the following activities:
• The Alabama Medicaid Agency serves as the administering agency for the HIV/AIDS Waiver. The operating agency is the Alabama Department of Senior Services. The Provider Audit Unit of the Medicaid Agency monitors the payments made to providers of waiver services. The Medicaid Agency is audited, externally by the Alabama Department of Public Examiners of Public Accounts.
• The Fiscal Agent Liaison Division/Contract Monitoring Unit monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews and targeted reviews of claims are performed when potential system errors are identified. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, service limitations and related services are compared to Medicaid policy and guidelines.
• Monthly reports of expenditures are received by the waiver coordinator in order to monitor irregular expenses. The CMS 372 report is generated annually which records cost effectiveness and cost comparisons. Provider records are audited annually or more frequently at th discretion of the Medicaid Agency.
• The entity responsible for conducting the periodic independent audit of the waiver program as required by the Single State Audit Act is the Alabama Department of Examiners of Public Accounts.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods fc discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., da presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations a formulated, where appropriate.

Performance Measure:
Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the waiver application

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of reviewed waiver service claims submitted for FFP that are specified in the participant's service plan

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The AMA has contracted with a fiscal agent to maintain the payment records on services received and billed under the HIV/AIDS Waiver. The OA ensures that all services and corresponding payments are coded and documented properly. The OA ensures that only those services included on the plan of care are billed for the HIV/AIDS Waiver participant.

The Fiscal Intermediary has edits in the system to ensure that the participant has Medicaid financial eligibility and HIV/AIDS Waiver eligibility before the claims are paid. The AMA reviews selected claim data to ensure that services are billed appropriately and according to the plan of care.

To ensure maximum reimbursement to services providers, the AMA is notified of any claims payment issues and will work with the OA and the fiscal intermediary to resolved the issues.

The AMA through the Decision Support System can generate adhoc reports to track payments and denials for each waiver participant as well as the cost for the entire waiver program.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
AMA has a Program Administrator within the Long Term Care Division that provides assistance to the OA to address individual problems as they are identified. All issues will be corordinated with the appropriate entity: Medicaid Eligibility Division, Fiscal Agent Liaison, etc., for resolution. If the issue cannot be resolved on that level, the issue will be reported to the Long Term Care Division Director for further intervention.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for

discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Alabama Medicaid Agency is responsible for establishing provider payment rates for AIDS Waiver services. Payments made by Medicaid to AIDS Waiver providers are on a fee-for-service basis and are based upon the following factors:

- Current pricing for similar services
- State-to-State comparisons
- Geographical comparisons within the state
- Comparisons of different payers for similar services

A procedure code is determined for each waiver service and a rate is assigned to each code. The Medicaid Management Information System (MMIS) pays the claim based upon the State's determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Rates established are reasonable and customary to ensure continuity of care, quality of care and continued access to care. Re-evaluatio of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and changes in the Consumer Price Index.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured th the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenu for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participatio including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid wai payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The System performs validation edits to ensure the claim is filled out correctly and contains sufficient information for processing. Edi ensure the recipient's name matches the recipient identification number (RID); the procedure code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any o these edits, it is returned to the provider.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State-determined pricing methodology applied to each service by provider type, claim type, recipient benefit or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by EDS personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writin schedule published in the Provider Insider, the Alabama Medicaid provider bulletin produced by EDS. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider

participates in electronic funds transfer (EFT), the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver service for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed ca entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limite fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limi fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

The State of Alabama Department of Senior Services is the operating agency for the HIV/AIDS Waiver. The services provided are Skilled Nursing, Skilled and Unskilled Respite, Personal Care and Companion Services, Homemaker and Case Management.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in t aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver service**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made b states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Direct Service Providers may reassign payments only to ADSS, the operating agency for the AIDS Waiver.

ii. Organized Health Care Delivery System. *Select one:*

○ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

◉ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

The Alabama Department of Senior Services (ADSS), and the direct service providers who subcontract with ADSS, all provide one or more waiver service and are therefore eligible to be an OHCDS. Providers may enroll directly with Medicaid if they choose to do so. Free choice of providers is assured by the policies and procedures in effect and practices carried out by the case managers. All qualified and available providers are enrolled and monitored to ensure that they meet the provider qualifications in the waiver document.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) o prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and othe services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-feder share of computable waiver costs. *Select at least one:*

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, suc as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of th non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ○ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ◉ **Applicable**

Check each that applies:

- ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- ☑ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is use to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including a matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

a) Intergovernmental Transfers from Public Hospitals; b) providers of waiver services; and c) The public hospitals transfer th funds to the Medicaid Agency in separate transactions. These public hospitals are not waiver providers.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-relate donations; and/or, (c) federal funds. *Select one*:

- ◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ○ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ○ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - **i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	33437.43	128894.00	162331.43	415438.00	225725.00	641163.00	478831.57
2	34747.32	134050.00	168797.32	432056.00	234754.00	666810.00	498012.68
3	36176.42	139412.00	175588.42	449338.00	244145.00	693483.00	517894.58
4	37623.06	144988.00	182611.06	467311.00	253910.00	721221.00	538609.94
5	39107.36	150787.00	189894.36	486004.00	264066.00	750070.00	560175.64

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	150	150
Year 2	150	150
Year 3	150	150
Year 4	150	150
Year 5	150	150

Appendix J: Cost Neutrality Demonstration

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The Average Length of Stay (ALS) on the AIDS Waiver was 304 days for reporting period 10/01/05 to 09/30/06.

The ALS was derived by dividing the total number of enrolled days for all waiver participants by the unduplicated number of participants which was obtained from the CM-372(S)report for the aformentioned reporting period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is a follows:

Cost figures for Factor D were derived from values contained in the Decision Support System (DSS) which were extracted by query with an inflation factor of 4%.

DSS provides the user the capability to detect; analyze, and report patterns in Medicaid program expenditures and utilization, as well as access, cost, use and quality. Information obtained from DSS is for program management, financial analysis, and ad hoc reporting, audit support. DSS allows the user to analyze and report access, quality, use, and cost of fee for service care.

The number of users was derived by DSS query. The information obtained for any DSS query contains data warehoused in the Medicaid Management Information System (MMIS).

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is a follows:

Cost figures for Factor D' were derived from values contained in the Decision Support System (DSS) with an inflation factor of 4%.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is a follows:

Cost figures for Factor G were derived from values contained in the Decision Support System (DSS) with an inflation factor of 4%. The figures are based on an institutional population with individuals who have a diagnosis of HIV/AIDS or a related illness.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is follows:

Cost figures for Factor G' were derived from values contained in the Decision Support System (DSS) with an inflation factor o 4%. The figures are based on an institutional population with individuals who have a diagnosis of HIV/AIDS or a related illness.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Case Management
Homemaker

Personal Care
Respite
Companion Services
Skilled Nursing

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populat the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**2100600.00**
Case Management	15 minutes	150	720.00	19.45	**2100600.00**	
Homemaker Total:						**161824.00**
Homemaker	15 minutes	100	416.00	3.89	**161824.00**	
Personal Care Total:						**889200.00**
Personal Care	15 minutes	120	1976.00	3.75	**889200.00**	
Respite Total:						**555397.60**
Unskilled Respite	15 minutes	50	940.00	3.62	**170140.00**	
Skilled Respite	15 minutes	63	1176.00	5.20	**385257.60**	
Companion Services Total:						**167767.44**
Companion Services	15 minutes	107	564.00	2.78	**167767.44**	
Skilled Nursing Total:						**1140825.40**
Skilled Nursing	1 hour	113	353.00	28.60	**1140825.40**	
				GRAND TOTAL:		**5015614.44**
				Total Estimated Unduplicated Participants:		**150**
				Factor D (Divide total by number of participants):		**33437.43**
				Average Length of Stay on the Waiver:		304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populat the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**2184840.00**
Case Management	15 minutes	150	720.00	20.23	**2184840.00**	
Homemaker Total:						**168480.00**
Homemaker	15 minutes	100	416.00	4.05	**168480.00**	
Personal Care Total:						**924768.00**
Personal Care	15 minutes	120	1976.00	3.90	**924768.00**	
Respite Total:						**573306.08**
Unskilled Respite	15 minutes	50	940.00	3.67	**172490.00**	
Skilled Respite	15 minutes	63	1176.00	5.41	**400816.08**	
Companion Services Total:						**174405.72**
Companion Services	15 minutes	107	564.00	2.89	**174405.72**	
Skilled Nursing Total:						**1186298.86**
Skilled Nursing	15 minutes	113	353.00	29.74	**1186298.86**	
				GRAND TOTAL:		**5212098.66**
				Total Estimated Unduplicated Participants:		**150**
				Factor D (Divide total by number of participants):		**34747.32**
				Average Length of Stay on the Waiver:		304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and popul the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J- Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**2272320.00**
Case Management	15 minutes	150	720.00	21.04	**2272320.00**	
Homemaker Total:						**175136.00**

Homemaker	15 minutes	100	416.00	4.21	175136.00	
Personal Care Total:						962707.20
Personal Care	15 minutes	120	1976.00	4.06	962707.20	
Respite Total:						600885.44
Unskilled Respite	15 minutes	50	940.00	3.91	183770.00	
Skilled Respite	15 minutes	63	1176.00	5.63	417115.44	
Companion Services Total:						181647.48
Companion Services	15 minutes	107	564.00	3.01	181647.48	
Skilled Nursing Total:						1233766.77
Skilled Nursing	1 hour	113	353.00	30.93	1233766.77	
				GRAND TOTAL:		5426462.89
				Total Estimated Unduplicated Participants:		150
				Factor D (Divide total by number of participants):		36176.42
				Average Length of Stay on the Waiver:		304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and popul the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J- Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						2363040.00
Case Management	15 minutes	150	720.00	21.88	2363040.00	
Homemaker Total:						182208.00
Homemaker	15 minutes	100	416.00	4.38	182208.00	
Personal Care Total:						1000646.40
Personal Care	15 minutes	120	1976.00	4.22	1000646.40	
Respite Total:						625445.68
Unskilled Respite	15 minutes	50	940.00	4.07	191290.00	
Skilled Respite	15 minutes	63	1176.00	5.86	434155.68	
Companion Services Total:						188889.24

Companion Services	15 minutes	107	564.00	3.13	188889.24	
Skilled Nursing Total:						1283229.13
Skilled Nursing	1 hour	113	353.00	32.17	1283229.13	
				GRAND TOTAL:		5643458.45
				Total Estimated Unduplicated Participants:		150
				Factor D (Divide total by number of participants):		37623.06
				Average Length of Stay on the Waiver:		304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per Use and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and popul the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J- Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						2457000.00
Case Management	15 minutes	150	720.00	22.75	2457000.00	
Homemaker Total:						189696.00
Homemaker	15 minutes	100	416.00	4.56	189696.00	
Personal Care Total:						1038585.60
Personal Care	15 minutes	120	1976.00	4.38	1038585.60	
Respite Total:						650005.92
Unskilled Respite	15 minutes	50	940.00	4.23	198810.00	
Skilled Respite	15 minutes	63	1176.00	6.09	451195.92	
Companion Services Total:						196131.00
Companion Services	15 minutes	107	564.00	3.25	196131.00	
Skilled Nursing Total:						1334685.94
Skilled Nursing	1 hour	113	353.00	33.46	1334685.94	
				GRAND TOTAL:		5866104.46
				Total Estimated Unduplicated Participants:		150
				Factor D (Divide total by number of participants):		39107.36
				Average Length of Stay on the Waiver:		304